EXHIBIT D

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UGNJ
777 Bloomfield Avenue
Glen Ridge, NJ 07028
973-429-0462 (phone) • 973-748-1236 (fax)
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IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
CHARLESTON DIVISION

IN RE: ETHICON, INC., PELVIC REPAIR SYSTEM PRODUCTS LIABILITY LITIGATION	**MDL No. 2327**
	2:12-md-02327
THIS DOCUMENT RELATES TO:	**HON. JOSEPH R. GOODWIN**
Kristy Manor, et al. v. Ethicon, Inc.., et al No. 2:12-cv-00878	

RULE 26 EXPERT REPORT OF KONSTANTIN WALMSLEY, MD

My name is Konstantin Walmsley. I have been retained by the Motley Rice Law Firm to give medical opinions related to Kristy Manor. I am being compensated at the rate of $500 dollars/hour. My curriculum vitae and schedule of previous testimony are attached to this report. All opinions set forth in this report are based upon my personal knowledge, as well as my review of the pertinent medical records, my education, training, skill, experience as a physician, and review of the pertinent medical literature. All of my opinions are based upon a reasonable degree of medical probability.

I am a licensed physician in the State of New Jersey and a board certified urologist. I am familiar with the evaluation and treatment of stress urinary incontinence. I have implanted transvaginal mesh and am familiar with the properties of these devices and proper implantation technique for these devices.

I am familiar with the evaluation and treatment of stress urinary incontinence. I have implanted transvaginal mesh, including mid urethral slings, and am familiar with the properties of these devices and proper implantation technique for these devices. Further, I am familiar with non-mesh options for the treatment of stress urinary incontinence including the pubovaginal sling. I have

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attended training provided by Ethicon, Inc. regarding the TVT device. I have explanted and performed other revision procedures on transobturator and retropubic mid-urethral slings including the TVT device.

Additionally, in light of my training, knowledge, experience and qualifications as set forth above and in the attached C.V., I am familiar with the medical complications that are generally associated with mesh repair surgery, and I am experienced in the recognition, diagnosis and treatment of patients suffering from complications caused by pelvic repair mesh implants.

The most common complications are pelvic pain, scarring in the vagina and pelvic floor, pain into the legs and thighs, dyspareunia, chronic inflammation of tissue, scar bands or scar plates in the vagina, vaginal shortening or stenosis, erosion, exposure or protrusion of mesh into and through tissues or organs, voiding dysfunction relating to pelvic floor scarring (de novo urinary urgency, urge incontinence, and incomplete emptying), and nerve entrapment. In diagnosing and treating patients with mesh related complications, I often determine the cause of the patients complications based upon an interview with the patient, a review of her medical records, and knowledge of her prior medical history.

I have reviewed the following medical records and depositions with accompanying exhibits pertaining to Kristy Manor:

- Jackson Healthcare for Women, P.A.;
- Southern Womens Health PLLC;
- University of Texas Southwestern Urology Clinic;
- Barnes Chiropractic;
- Walmart Stores Pharmacy Clinic;
- LabCorp Birmingham and of America;
- Saint Dominic Jackson Memorial Hospital;
- Mississippi Baptist Health System and Medical Center;
- Quest Diagnostics at Nichols Institute;
- Medicaid of Mississippi;
- University of Texas Southwestern Pathology Department
- River Oaks Hospital and Womans Hospital;
- Women's Specialty Center Jackson -Southeast Urogynecolog;y
- Ovation Womens Wellness;

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- AmeriPath Dermpath Diagnostics, Inc;
- Gary Glenn Bolton, MD;
- University of Mississippi Medical Center;
- Mississippi Premier Plastic Surgery;
- The Woman's Clinic;
- Social Security Administration;
- Centers for Medicare and Medicaid Services (Region 4) Medicare Part A & B;
- Shaw's Pharmacy;
- GI Associates and Endoscopy Center;
- Merit Health Woman's Hospital; and
- MEA Medical Clinics, Inc.

In addition to the review of the medical records listed above, I performed an independent medical examination of Mrs. Manor on April 26th, 2016. I have also reviewed the following medical literature and other TVM related documents and have relied, in part, on the documents below in addition to my medical and clinical experience in forming my opinions:

- AMA 8.08
- TVT Instructions for Use
- C.G. Nilsson et al "Seventeen years' follow-up of the tension free vaginal tape procedure for female stress urinary incontinence." Int. Urogynecol. J. (2013) 24:1265-69
- P. Hilton "A clinical and urodynamic study comparing the Stamey bladder neck suspension and suburethral sling procedures in treatment of genuine stress incontinence" British Journal of Obst. & Gynecol (February 1989, Vol 96, pp. 213-220
- H. Enzelsberger et. al "Comparison of Burch and Lyodura Sling Procedures for Repair of Unsuccessful Incontinence Surgery" Obstet & Gynecol, Vol 88, No. 2, August 1996
- A.S. Arunkalaivanan et al "Randomized trial of porcine dermal sling (Pelvicol implant) vs. Tension-free Vaginal Tape (TVT) in the Surgical treatment of stress incontinence: a questionnaire based study" Int. Urogynecol J (2003), 14: 17-23

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- K. Guerrero et al "A randomized controlled trial comparing two autologous fascial sling techniques for the treatment of stress urinary incontinence in women: short, medium and long-term follow-up" Int. Urogynecol J (2007) 18:1263-1270
- B. Welk et al, "Removal or Revision of Vaginal Mesh Used for the Treatment of Stress Urinary Incontinence" JAMA Surgery, Published Online September 9, 2015.
- E. Petri et al., "Complications of synthetic slings used in female stress urinary incontinence and applicability of the new IUGA-ICS classification" Eur. J. of Obstet. & Gynecol. and Reprod. Bio. 165 (2010) 347-351
- B. Klosterhalfen et al., "Functional and morphological evaluation of different polypropylene-mesh modifications for abdominal wall repair" Biomaterials (1998) 2235-46
- J. Anger et al., "Complications of Sling Surgery Among Female Medical Beneficiaries" Obstet. & Gynecol. Vol. 109, No. 3 (March 2007)
- P. Moalli et al, "Tensile Properties of five commonly used mid-urethral sling relative to the TVT" Int. Urogynecol J (2008) 19:655-663
- A. Clave et al, "Polypropylene as a reinforcement in pelvic surgery is not inert: comparative analysis of 100 explants" Int. Urogynecol J (2010) 21:261-270
- O. Chinthakanan et al., "Mesh Removal Following Sling/Mesh Placement: A Multicenter Study" Int. Urogynecol. J (2014) 25 (Suppl 1) S-139-40
- O. Chinthakanan et al, "Indication and Surgical Treatment of MidUrethral Sling Complications: A Multicenter Study" Int. Urogynecol. J (2014) 25 (Suppl 1) S-142-43
- E. Petri et al., "Comparison of late complications in retropubic and transobturator slings in stress urinary incontinence" Int. Urogynecol. J. (2012) 23:321-325
- S. Abbott et al., "Evaluation and management of complications from synthetic mesh after pelvic reconstructive surgery: a multicenter study" American J. of Obstet. & Gynecol (February 2014) 163.e1-8.

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- G. Agnew et al, "Functional outcomes following surgical management of pain, exposure or extrusion following a suburethral tape insertion for urinary stress incontinence" Int. Urogynecol J. (2014) 25:235-239
- J. Duckett et al, "Pain after suburethral sling insertion for urinary stress incontinence" Int. Urogynecol J. (2013) 24:195-201
- C. Skala et al., "The IUGA/ICS classification of complications of prosthesis and graft insertion" Int. Urogynecol J (2011) 22:1429-1435
- K. Svabik et al., "Ultrasound appearances after mesh implantation – evidence of mesh contraction or folding?" Int. Urogynecol J. (2011) 22:529-533
- A. Rogowski et al., "Mesh retraction correlates with vaginal pain and overactive bladder symptoms after anterior vaginal mesh repair" Int. Urogynecol. J. (2013) 24:2087-2092

Clinical History

- On August 24th, 2005, Mrs. Manor memorialized having urinary incontinence.

- On February 7th, 2007 Mrs. Manor saw Dr. Robert Harris with complaints of stress urinary incontinence requiring 3 pads/day usage. Physical exam revealed urethral hypermobility with anterior and posterior prolapse and a positive cough stress test.

- On March 23rd, 2007, Mrs. Manor underwent urodynamic testing demonstrating intrinsic sphincter deficiency, bladder pain at a bladder capacity of 350 cc, and mixed urinary incontinence

- On April 3rd, 2007, Dr. Speights performed cystoscopy and reviewed her urodynamic study which revealed intrinsic sphincter deficiency (ISD). She had been considering surgery for this but preferred nonsurgical treatment at that time.

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- On August 24th, 2007, Drs. Harris and Speights performed an anterior and posterior repair as well as a TVT-O procedure. The procedure occurred uneventfully with the patient having a normal cystoscopy and estimated blood loss of 50 cc. With regards to the sling insertion, Dr. Harris documents the following. "We grasped the suburethral area with the Allis clamps and injected about 5 mL of 0.25% Marcaine with epinephrine. A small midline vaginal incision was made at the mid-urethral area at about 1.5 cm. Metzenbaum scissors were used to begin the sharp resection of the periurethral tissue toward the obturator foramen on either side. The wing-tip guide was pierced to the right periurethral incision and the Helical inserter of the sling was guided down this and pierced through the obturator membrane, and guided close to the side of the bone, and back out through the small mark on the skin. The exact same procedure was undertaken on the opposite side. The sling was then pulled up to within about 1.5 cm of the urethra and I held the suction 1ip between the sling and the urethra while Dr. Speights pulled the plastic sheath from the polypropylene sling. Again, it was in excellent position beneath the urethra. He cut the extra sling of the small exit wounds and closed these with Dermabond. adhesive. We copiously irrigated the vagina and closed the remaining subepithelial epithelium incision with 2.0 chromic in a running locking fashion."

- On August 27th, 2007 Mrs. Manor initially underwent a successful trial of void, voiding 250 cc of fluid that had been instilled in her bladder. Because of recurrent retention problems, she was subsequently taught how to catheterize herself and prescribed Levaquin.

- On September 21st, 2007, she saw Dr. Harris with complaints of mixed urgency urinary incontinence, as well as intermittent vaginal bleeding and a sensation of vaginal bulge. She was prescribed Vesicare and Bactrim DS. She was instructed to perform Kegel pelvic muscle exercises, schedule voids every 1-2 hours while awake, and limit caffeine intake.

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- On November 27th, 2007, she saw Dr. Harris with complaints of nearly continuous mixed urinary incontinence as well as vaginal pain in the left vulvar area with sitting and with intercourse. Other pain with intercourse also occurred in different positions and was improving. She was recommended to perform Kegel/pelvic muscle exercises, begin perineal massage, limit caffeine and use Pramosone ointment.

- On November 7th, 2008, Mrs. Manor saw Dr. Fred Ingram with complaints of intermittent pain (worse when sitting down), a feeling of vaginal bulge in the area of her sling surgery, the need to strain or push to urinate, urgency urinary incontinence only partially resolved with Vesicare and nocturia x 4. She described having pain 60% of the time, more on the left side than the right side. She was prescribed Enablex for her urge incontinence, and Lidocaine ointment, Elavil, Neurontin, and prn Motrin for her pain. She was diagnosed with neuropathic pain and vestibulitis at that time.

- On June 7th, 2011, she saw Dr. Philippe Zimmern. By his memorialized records, Mrs. Manor was unable to void for the first week after her 8/2007 surgery and had to learn intermittent catheterization. Postoperative records document that she voided but in fact she said that she had a large residual at the time and was not sure why this was recorded as such. Her voiding problems persisted and although she was not catheterizing anymore, she was going to the bathroom very frequently, every hour, had nocturia times 5 to 6, and had urinary tract infections by symptoms and urinalysis documentation although not always symptomatic. On follow-up notes, she had documented chronic residuals, some up to 200 mL at a time. In the review of notes brought to Dr. Zimmern, he reviewed the 2007 cystoscopy as well as the urodynamic testing from March of 2007, which revealed a bladder capacity of about 360 mL. There was normal compliance, and no evidence of detrusor overactivity. The patient leaked at Valsalva at 300 mL. Voiding pressures were not recorded but her maximum flow rate

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was at 60 mL/sec. At the time of her visit to Dr. Zimmern, Mrs. Manor's incontinence was present mostly at night. She often woke up leaking or had urgency and then leaked. She also experienced leakage after voiding, which could be post bladder contraction spasms. She also noted leakage with jogging, rarely with coughing or sneezing. According to the preoperative notes, she used to wear 3 pads per day and was wearing about 4 a day, mostly tampons because she had become very allergic to pads and very thin liners. She had no symptoms of pelvic prolapse. She described pain with intercourse, about level 4 out of 10, sometimes more depending on the position. She felt that the vagina was curved to the left side. She knew her uterus was in place. Her husband did not report any pain during intercourse or penile scratches. She denied constipation. She felt a ledge posteriorly. Manual splinting helped at times. She described fears of tearing vaginally, one right posteriorly along the skin tags of the introitus slightly to the left of the midline. Another one on the right side of the introitus and a third one by the clitoris. She also had had some vaginal discharge although she did not know whether this was physiologic or not. On physical exam, Dr. Zimmern notes: "A small tear of the level of the clitoris, an area of redness right to the midline from the posterior introitus. There is a midline scar from the prior posterior repair and this is slightly off that area. This could possibly be helped by a perineum plastic revision but this is not certain. There is another area inside of the introitus on the left side next to 2 small skin tags, which are hymenal remnants. There is no visible lesion there but the patient feels some induration there as well as she does feel some induration in the midline right where the perineorrhaphy was done as part of her posterior repair back in 2007. Operative note described the use of "2-0 Ethibond to plicate the retrovaginal septum in the midline." She may be feeling the Ethibond sutures, which did not dissolve. The rest of the repair according to the operative note was done with absorbable sutures using Vicryl and chromic catgut. Ethibond sutures can occasionally be found and removed surgically and that could maybe alleviate her discomfort in that area. The rest of the vaginal examination was done with the use of a small speculum. The posterior repair was intact with the

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midline scar and no obvious recurrence was noted with point AP at -3, anteriorly point A is at -3. On palpation, the tape was tented on both the left and the right side and there was some palpable induration below the bladder neck on the right side. She was also tender on examination. It is possible that the TVT-O sling is higher than expected and that may be causing some constriction of the bladder neck leading to some voiding difficulty as experienced by the patient since the tape was inserted. The uterus was palpable at the top of the vagina. It was about 6 cm from the introitus. Levator muscles were not tender. There was no significant vaginal discharge and no evidence of yeast infection." Urodynamic testing and cystoscopy were recommended.

- On April 23rd, 2013 she saw Dr. Erica Ory. She was complaining of pelvic pain. For the past years she had noticed moderate pain in the midline. Her pain occurred only occasionally. The pain had stayed about the same since it started. She stated it all started since having an A&P repair and bladder suspension in 2007. She complained of urinary incontinence. She states that when she coughs, sneezes, or exercises she will lose urine. She also complains of urinary urgency. She does not have to wear a pad. She denied dysuria. She complained of constipation. Her bladder and adnexa were palpably tender on exam.

Methodology

My general opinions based upon my clinical experience and review of medical and scientific literature and well as my medical education, knowledge, training, practice, and clinical experience.

My case specific opinions are based upon a differential diagnosis methodology. In determining the specific cause of an injury in the medical context it is necessary to "rule in" potential causes of the injury, and then by process of elimination, to "rule out" the least likely causes to arrive at the most likely cause.

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Opinion No. 1

Facilitating informed consent is an integral part of the practice of medicine. I agree with AMA 8.08 on informed consent. The patient's right of self-decision is particularly important when surgical intervention regarding a permanent medical device is being considered by the patient.

Before a surgeon can inform a patient on the risks/benefits/alternatives to any procedure, including the TVT, the surgeon must be informed on the risks/benefits/alternatives. I have read and relied on Instructions for Use (IFU) for medical devices when informing myself on the risks/benefits/alternatives to a given procedures – including mid-urethral slings. I incorporate the risks and complications referenced in the IFU into my risk benefit conversation with the patient. I expect the risk and complication information as presented in the IFU to be accurate.

It is my opinion the IFU for the TVT in 2007 was not sufficient to enable informed consent from the patient. The TVT IFU provided:

ADVERSE REACTIONS

- Punctures or lacerations of vessels, nerves, bladder or bowel may occur during needle passage and may require surgical repair.
- Transitory local irritation at the wound site and a transitory foreign body response may occur. This response could result in extrusion, erosion, fistula formation and inflammation.
- As with all foreign bodies, PROLENE mesh may potentiate an existing infection. The plastic sheath initially covering the PROLENE mesh is designed to minimize the risk of contamination.
- Over correction i.e. too much tension applied to the tape may cause temporary or permanent lower urinary tract obstruction.

ACTIONS

Animal studies show that implantation of PROLENE mesh elicits a minimal inflammatory reaction in tissues, which is transient and is followed by the deposition of a thin fibrous layer of tissue which can grow through the interstices

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of the mesh, thus incorporating the mesh into adjacent tissue. The material is not absorbed, nor is it subject to degradation or weakening by the action of tissue enzymes.

The words "transitory" and "transient" carry a specific medical meaning. Mosby's medical dictionary defines transient as "pertaining to a condition that is temporary." Using the word transient to describe the human body's foreign body response to the TVT mesh implies the response dissipates with time. In my experience, this does not accurately describe the human body's foreign body response to transvaginal placed mesh.

In my experience when dealing with synthetic mesh-induced foreign body response, the degree of inflammation and scarring around the mesh is intense and chronic. More often than not, when removing exposed mesh, I am unable to completely remove the entire mesh implant because of the intensity of inflammation and extensive scarring induced by mesh incorporation into the host tissues. Moreover, in all of my experiences removing mesh, residual scarring of the vagina and peri-vaginal tissues persists and is even more severe in the instances where residual pelvic mesh is left in the patient.

The TVT IFU does not mention: mesh contraction; dyspareunia; mesh shrinkage; scar plate formation; or the difficulty in removing mesh in the event of an adverse event. These events are all part of my informed consent conversation today. I have treated patients implanted with mid-urethral slings, including the TVT for these conditions. These events were reported in the mid-urethral sling literature prior to when Mrs. Manor was implanted. In my opinion, a patient considering a mid-urethral sling cannot be properly consented without discussing these potential adverse events.

Opinion No. 2

Safer alternatives designs and procedures existed in 2007 that have a lesser risk of erosion and dyspareunia with substantially equivalent efficacy.

In 2007, alternative successful and safer sling alternatives were available including autologous fascial slings using rectus fascia sutured to the bladder neck and tied to itself over the rectus fascia. Mrs. Manor was unable to receive proper informed consent relating to this safer alternative because of the lack of

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information in the TVT IFU inherent to the risks of using synthetic mesh in the area of the pelvis and vagina. As such, Drs. Harris and Speights were not able to warn Mrs. Manor of the subsequent complications she has suffered from.

Opinion No. 3

Mrs. Manor suffered vaginal sling contraction and scar plate formation as a result of the physical properties of the TVT device. These conditions are documented in the medical records.

A. Contraction/Shrinkage

Mrs. Manor's TVT contracted post implantation. Dr. Zimmern documented such during his examination documenting that the tape "was tented on both the left and the right side and there was some palpable induration below the bladder neck on the right side."

I have observed "tented" pieces of transvaginal mesh in my clinical practice that is the result of post-implantation contraction or shrinkage of the mesh.

B. Scar Plate

During his physical examination of Mrs. Manor, Dr. Zimmern identified that "there was some palpable induration below the bladder neck on the right side" in the area of Mrs. Manor's sling.

I have observed scar plate formation in patients such as Mrs. Manor who have had TVT slings implanted.

Opinion No. 4

Mrs. Manor's vaginal pain and dyspareunia was caused by contraction of the TVT device, and scar plate formation. Recognized causes of dyspareunia following synthetic sling surgery include: (1) erosion/extrusion; (2) mesh contraction; (3) paraurethral banding; (4) scarring with reduced elasticity; (5) infection and inflammation including but not limited to vestibulitis; (6)

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neuromuscular injury (7) lichen sclerosis; (8) vaginal tissue atrophy; and (9) pelvic floor dysfunction.

I am able to rule in contraction and scarring as potential causes of Mrs. Manor's vaginal pain and dyspareunia in 2012. These conditions are documented in the medical records of Dr. Zimmern as previously stated above. Further, palpation on exam produced pain in Mrs. Manor.

Pain produced on palpation on exam enables me to rule in contraction and scarring as a potential causes of Mrs. Manor's dyspareunia.

I am able to exclude paraurethral banding as a cause of Mrs. Manor's dyspareunia and vaginal pain because I have seen no paraurethral banding documented.

I am able to exclude vestibulitis, and lichen sclerosis as causes of Mrs. Manor's vaginal pain and dyspareunia. There was one instance where the diagnosis of vestibulitis and neuropathic pain was entertained, in November of 2008. These diagnoses however were not ever documented in Mrs. Manor's medical records. The medications offered to treat these conditions were totally ineffective by patient report. Moreover, Dr. Zimmern's consultation revealed no evidence of these conditions. Neuromuscular injury is excludable as the cause of Mrs. Manor's dyspareunia.

Vaginal tissue atrophy is excludable as the cause of Mrs. Manor's dyspareunia as she never was diagnosed with this condition and is pre-menopausal as well, making the likelihood of this condition practically impossible.

I am able to exclude pelvic floor dysfunction as the cause of Mrs. Manor's dyspareunia, as reflected by Dr. Zimmern's noting the absence of levator muscle tenderness during his evaluation. The absence of documented tenderness to the pelvic floor musculature enables me to reasonably exclude pelvic floor dysfunction as a potential cause of Mrs. Manor's dyspareunia.

Opinion No. 5

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Mrs. Manor continues to have dyspareunia presently. As part of my expert review and preparation of my opinion regarding Ms. Manor, I performed an independent medical exam of this patient on April 26th, 2016. At that time, the patient reported several bothersome symptoms including voiding dysfunction and dyspareunia. Her voiding dysfunction consisted of urinary incontinence, primarily urgency urinary incontinence. She also described urgency, frequency, and nocturia. With regards to her pelvic pain, she sensed a pinching and some tightness over her groin areas especially at times of ovulation. She described having moderate dyspareunia when she is side-side or in an exaggerated missionary position Additionally, she also occasionally feels a pulling/pinching sensation during sex. She described a pain sensation on the within the vaginal canal that on physical exam was reproducible on exam in the left side of her vaginal introitus, in the area of her sling

Additional significant findings include indurated tissue in the area of her sling on both the left and right sides of the vaginal canal. As part of the foreign body reaction to synthetic mesh the periurethral, perivesical, and vaginal tissues create dense fibrotic scar tissue which compromises the elasticity and compliance of these tissues. As such, when patients present with complications from synthetic mesh slings, they tend to develop a combination of voiding dysfunction, sometimes manifest as obstructive in nature, in addition to urinary incontinence that is often both stress incontinence in combination with urgency urinary incontinence. This relates to a combination of factors, one being the development of non-compliant "pipestem" urethral tissues that are unable to coapt and therefore hold urine; the second factor relates to a combination of (1) inflammation rendering the bladder muscle (or detrusor muscle) unstable, as well as (2) scarring of the bladder muscle adjacent to the synthetic mesh foreign body response, in which the bladder muscle's ability to contract is compromised because of scarring and fibrosis. The patient was given samples of Myrbetriq 50 mg daily to assess whether she had any improvements with regard her urgency urinary incontinence symptoms.

Opinion No. 6

Ms. Manor's future prognosis as it relates to her pelvic pain, dyspareunia, and voiding dysfunction is guarded. Because she has pelvic mesh still inside of

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her body, she will continue to suffer from pelvic pain and dyspareunia. Moreover, she has pelvic tenderness and residual scar tissue in the area where her mesh erosion was treated. Even if she were to have all of her mesh removed, the surgery require to execute this procedure is extensive, complicated, and almost exclusively performed in tertiary academic centers. I anticipate that if heroic surgery were performed to remove all of her mesh that she would develop further scarring and fibrosis inherent to this procedure.

In as much an autologous fascial sling or other procedures (not involving synthetic mesh) for incontinence might be considered if her mesh were to be removed, these would be inappropriate at the current time because of the fact that she still has a mesh sling present. Autologous fascial slings placed in the setting of scar tissue, a likely finding should she have her sling removed, would have a lower success rate and a higher complication rate than if it were performed in the absence of scarring. For this reason, Mrs. Manor is not a candidate for this type of surgery and is best treated with medical therapy in combination with lifestyle modifications and pelvic floor physiotherapy. Although these interventions should be somewhat helpful, they most certainly will not resolve the voiding dysfunction she currently suffers from.

With regards to her dyspareunia, her symptoms might be ameliorated with sling removal. Once again, this would be a heroic procedure performed in a tertiary academic center and would likely create further fibrosis and scarring which would more likely than not result in persistent dyspareunia. In summary, within a reasonable degree of medical certainty, the voiding dysfunction, pelvic pain, and dyspareunia will be a lifelong condition for this patient.

Sincerely,

Konstantin Walmsley, M.D.